STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455713	A. Building B. Wing	08/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at San Antonio	50 Briggs Ave. San Antonio, TX 78224

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to ensure the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for 2 of 16 residents (Residents #9 and #63) reviewed for accidents and hazards. 1. Resident #9 was observed with her own smoking paraphernalia which included a lighter (a self-contained ignition source used to lite cigarettes) and was observed smoking on the facility property without supervision and or at the assigned agreed upon times for supervised smoking. 2. Resident #106 was discovered with smoking paraphernalia which included a lighter and cigarettes, and was actively smoking, while receiving oxygen therapy, in his bathroom twice, once on 8/12/2025 and again on 8/21/2025. The noncompliance was identified as PNC. The IJ began on 6/13/2025 and ended on 8/25/2025. The facility had corrected the noncompliance before the survey began. These failures could have exposed residents to harm by neglecting to provide supervision. The findings included:The findings included: 1. A record review of Resident #9's admission record dated 8/29/2025 revealed an admission date of 6/2/2025 and a discharge date of 8/27/2025 with diagnoses which included chronic obstructive pulmonary disease (COPD, a group of lung diseases that cause airflow obstruction and breathing difficulties), left lower leg amputation, intermittent explosive disorder (recurrent episodes of impulsive, aggressive, and violent behavior that is disproportionate to the triggering situation), and diabetes mellitus II (a chronic condition where the body does not use insulin effectively or does not produce enough insulin and results in high concentrations of sugars in the bloodstream with potential negative outcomes). A record review of Resident #9's quarterly MDS dated [DATE] revealed resident #9 was a [AGE] year-old female admitted for long term care with supports for safe supervised smoking. Resident was assessed with a BIMS score of 15 out of 15 which indicated no cognitive impairment. A record review of Resident #9's care plan dated 8/27/2025 revealed, problem; resident is a smoker . instruct Resident about smoking risks and hazards and about smoking cessation aids that are available . instruct residents about the facility policy on smoking locations, times, safety concerns, . notify charge nurse immediately if it is suspected resident has violated facility smoking policy . observe clothing and skin for signs of cigarette burns . A record review of Resident #9's nursing progress notes revealed on 6/13/2025 at 4:16 AM LVN F documented, patient noted going into (another residents) room multiple times throughout the night and taking patient out to smoke. A record review of Resident #9's nursing progress notes revealed on 6/15/2025 at 11:47 AM LVN X documented, resident observed outside in courtyard smoking with another Resident, resident was redirected. When nurse asked for lighter and cigarette, resident refused and stated she could smoke outside. Resident nurse notified. During an interview on 8/30/2025 at 1:51 PM LVN F stated Resident #9 would often smoke unsupervised and at unassigned time. LVN F stated Resident often had her own cigarettes and lighter and would surrender the lighter when asked but would often obtain another lighter, most likely from when she would sign herself out on pass. smoked out in the courtyard unsupervised and reported to the ADON and previous DON. LVN F stated there was a risk for burns. LVN F stated he recalled his (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	documentation on 6/12/2025 at 4 AM when he observed Resident #9 in the facility courtyard smoking cigarettes. LVN F stated he reported the incident at the change of shift to the previous DON and the ADON. 2. Record review of Resident #63's admission record dated 8/30/2025 revealed an admission date of 5/14/2025 with diagnoses which included malnutrition, anxiety, pain, hypertension (high blood pressure), muscle spasms / weakness, reflux, and chronic obstructive pulmonary disease. A record review of Resident #63 quarterly MDS dated [DATE] revealed Resident #63 was a [AGE] year-old male admitted for long term care with supports for safe supervised smoking. Resident #63 was assessed with a BIMS score of 11 out of a possible 15 which indicated moderate cognitive impairment. A record review of Resident #63's physicians order dated 5/14/2025 revealed the physician prescribed for Resident #63 to receive continuous oxygen therapy every shift every day and night. Record review of Resident #63's care plan dated 8/30/2024 revealed that he was an intermittent smoker (start date 5/14/2025) with a revision on 8/12/2025 indicating that he was noncompliant with the smoking policy and smoking in his bathroom and was educated/acknowledged smoking agreement. A record review of the facility's event report dated 8/12/2025 revealed at 4:00 PM the Social Worker and LVN A discovered Resident #63 in his bathroom smoking while receiving oxygen therapy via a nasal cannula and an oxygen concentrator. A record review of the facility's event report dated 8/21/2025 revealed at an unknown time prior to 4:00 PM LVN A and CNA B discovered Resident #63 was in his bathroom smoking while receiving oxygen therapy via a nasal cannula and an oxygen concentrator. During an observation and interview on 8/28/2025 at 1:40 PM revealed Resident #63 was in his room and was assisted to pack and gather his belongings to discharge to another facility. Resident #63 stated he was discharged related to his episodes of smoking in his rooms' bathroom. Resident #63 stated he did not participate in the supervised assigned smoke breaks due to his inability to participate in the smoke break without his oxygen therapy. Resident #63 stated he could not endure very long without his oxygen because of his COPD. During an interview on 8/28/2025 at 1:50 PM LVN A stated she and the SW discovered Resident #63 smoking in his bathroom twice in August 2025. LVN A stated the ADON, the DON, and the Administrator were aware of Resident #63's smoking incidents. LVN A stated Resident #63's smoking could have had serious injury potential to include fires and or burns. LVN A stated the incidents were reported to the facility's leadership who implemented safety measures which included assessing peer residents who smoke for smoking paraphernalia and monitoring Resident smokers for safe smoking practices. LVN A stated Resident #63 was monitored and reviewed for safety every 2 hours every day until he was discharged . During an interview on 8/28/2025 at 4:10 PM the ADON stated she was aware of Resident #63's smoking incidents while he was on oxygen therapy and had reviewed the incidents in the morning IDT meetings with the DON and the Administrator and could not recall anyone discussing a report to the state agency for the incidents. During an interview on 8/28/2025 at 5:00 PM the Administrator stated she had received a report from nursing staff that Resident #9 and Resident #63 had a history of smoking unsupervised and at unassigned times. The Administrator stated LVN A and the SW reported that Resident #63 had been caught smoking in his bathroom on 8/12/2025 and again on 8/21/2025. The Administrator stated the facility could no longer meet Resident #63's and Resident #9's needs for safe smoking and non-compliant behavior and discharged the Residents. The Administrator stated the IDT and herself had not considered the incidents as incidents which were reportable to the state agency and had not reported the incidents to the state agency. During an interview on 8/29/2025 at 4:40 PM NP C stated he was the NP for the MD and was responsible for Resident #63's medical care. NP C stated Resident #63 had a need for oxygen therapy related to his poor gas exchange and should never be able to smoke while receiving oxygen therapy. NP C stated the practice was dangerous not only to Resident #63 but to the public to include a potential for fires and explosions. A record review of the facility's smoking policy dated 2017 revealed It is the policy of this home that: All residents who smoke will be supervised. Smoking will be permitted in designated safe area(s) only. Oxygen equipment is not permitted in the smoking area(s). The minimum safe (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	distance for oxygen equipment from the smoking area is 50 feet. Residents not complying with the home's smoking policy may be discharged from the home. PNC verification A record review of the facility's Ad Hoc QAPI meeting documentations titled AD Hoc QAPI Meeting / Four Point Plan of Correction Agenda and Summary revealed the Ad Hoc committee members met which included the Medical Director, the Administrator, the DON, the ADON, the Maintenance Director, the Housekeeping Supervisor, the Social Worker, and the Business Manager. Further review revealed an action plan which included:1. Corrective actiona. What specifi9c action would you take for the identified residents? i. Identify residents who smoke ii. Provide re-education regarding safe smoking practices completed (policies.) iii. Proper notification to administration regarding non-compliance with smoking policy. iv. Monitoring of system to ensure compliance.2. Identification of othersa. What other residents might be a risk in the same deficient practice and why? All smokers could be potentially at risk for committing deficient practice. Therefore, continued reeducation of smoking policy has been implemented. Smokers were invited to resident council meeting to discuss smoking practices and ensure compliance with smoking policy.3. Systemic changesa. what changes would you make based on the results of your root cause analysis? Administrator, director of nursing, and assistant director of nursing will closely monitor smoking system and ensure compliance. Admissions - to identify smoker status prior to administration and communicate status with nursing team. Nurses have been in service on ensuring safe smoking practices are followed based on smoking policy and transparent communication will be required of non-compliance with administration and nursing administration teams.b. How will changes be communicated to staff? In services and one-on-one education on updated policies will be provided by the administrator and nurse managers including the director of nurses.c. Identification of non-compliant residents who smoke must be communicated to the administration team for interventions and safety practices put in place.4. Monitoringa. How will you sustain compliance? By making compliance monitoring rounds, education of staff and residents as appropriate.b. How do you plan to monitor corrective action? When and how long will monitoring occur? Monitoring will be ongoing. It will be monitored by all department managers to ensure compliance and reviewed monthly during QAPI meetings until further notice.c. Resident council will be included to provide smoking policy and ongoing education regarding safe practices. A record review of the smoker's club Resident council meeting dated 8/18/2025 revealed 10 residents which included Resident #9 and #63 received a review of the facility's smoking policy, It is the policy of this home that: All residents who smoke will be supervised. Smoking will be permitted in designated safe area(s) only. Oxygen equipment is not permitted in the smoking area(s). The minimum safe distance for oxygen equipment from the smoking area is 50 feet. Residents not complying with the home's smoking policy may be discharged from the home. A record review of the facility's in-service dated 8/21/2025 titled Smoking Supplies revealed the entire staff had received the in-service which included, all smoking supplies must be kept in smoking box no resident should be smoking in Rome all residents found with supplies for smoking must be taken away and notify the administrator. A record review of the facility's AdHoc QAPI files dated 8/21/2025 revealed a statement authored by the DON which included, on 8/21/25 myself and a DON rounded and searched all residents who smoke for any smoking paraphernalia smoking paraphernalia was found on any residence all smoking residents were able to verbalize they can only smoke during scheduled smoke breaks. Further review revealed the DON and the ADON signed the statement. A record review of the facility's AdHoc QAPI files dated 8/21/2025 revealed a monitoring worksheet for Resident #63 dated from 8/21/2025 until 8/27/2025. Further review revealed Resident #63 was monitored every 2 hours for safety and behavior without incident. During an observation and interview on 8/28/2025 at 1:40 PM revealed Resident #63 was in his room and was assisted to pack and gather his belongings to discharge to another facility. Resident #63 stated he was discharged related to his episodes of smoking in his rooms' bathroom. Resident #63 stated he did not participate in the supervised assigned smoke breaks due to his inability to participate in the smoke break without his oxygen therapy. Resident #63 stated he could not endure (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	very long without his oxygen because of his COPD. During an interview on 8/28/2025 at 1:50 PM LVN A stated she had received training for safe smoking practices which included monitoring residents for smoking paraphernalia and had monitored Resident #63 every 2 hours when she was on shift to do so. During an observation and interview on 8/27/2025 at 11:39 AM revealed the facility's designated smoking area, the courtyard, where 6 residents assembled for a smoke break. Further review revealed the Activities Director supplied the residents with cigarettes and lite the cigarettes for the residents. The Activities Director was observed to supply clothing protectors for residents who had a need for clothing protectors. The Activities Director stated the facility had developed and implemented a smoking program for residents which included 4 smoke breaks on Monday through Friday, four times a day, at 9:30 AM, 11:30 AM, 1:30 PM, and again at 4:00 PM. The Activities Director stated she organized and supervised the residents smoke breaks which included the storage of residents' cigarettes and lighters in a locked room at the nurse's station. During an observation and interview on 8/29/2025 at 4:33 PM revealed Resident #20, Resident #1, Resident #63, and Resident #36 assembled in the courtyard for a supervised smoke break. Residents #20, #1, #63, and #36 stated they smoked while supervised at the smoke breaks and the staff kept their cigarettes and lighters. During an interview on 8/28/2025 at 11:00 AM LVN X and LVN Z stated the activities Director would coordinate and supervise the smoke breaks for residents Monday through Friday and the nurses would take turns supervising the smoke breaks on the weekends. LVN X and LVN Z stated the cigarettes and lighters were stored locked in the medication room and the nurses would provide the cigarettes. LVN X stated no one should smoke in the facility and any violations would be reported to the leadership to include the Administrator and the DON. During an interview on 8/28/2025 at 4:10 PM the ADON stated she had reviewed the facility smokers several times during June 16/2025 through 8/21/2025 to include monitoring for smoking paraphernalia and safe smoking times with supervision. The ADON stated she and the entire staff had been in serviced several times for safe smoking policies and reporting unsafe smoking practices. During an interview on 8/28/2025 at 5:00 PM the Administrator stated she became aware of Resident #9's and Resident #63's unsafe smoking behaviors in June 15/2025 and in August 12th and august 21st 2025 and began an investigation on 8/13/2025 which concluded with an Ad Hoc QAPI meeting, a plan of correction which included systemic changes, increased monitoring for safe smoking practices and a safe discharge for residents #9 and Resident #63 to facilities which could meet their needs for safe smoking to include smoking cessation efforts.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the residents were free from chemical restraints not required to treat the residents' medical symptoms for 1 (Resident #60) of 6 residents reviewed for unnecessary medications.The facility failed to ensure Resident #60 received a gradual dose reduction for anti-psychotic medication, Zyprexa. This deficient practice could affect any resident receiving medications and could result in adverse effects and ultimately a decline in physical condition.The findings were:Review of Resident #60's face sheet dated 8/30/35 revealed she was admitted to the facility on [DATE] with diagnoses including Vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, Major Depressive Disorder, recurrent, severe with psychotic symptoms, Mood disorder due to known physiological condition with mixed features and Generalized anxiety disorder. Review of Resident #60's History and Physical, dated 2/18/25, revealed her BIMS was 0 of 15 reflective of severe cognitive impairment. Review of a prescription order, dated 1/4/24, revealed Resident #60 was prescribed Olanzapine (Zyprexa) tablet; 5 mg, 1 tablet, oral, once a day. Review of Resident #60's consolidated orders from 7/29/25 to 8/29/25 revealed an order for Olanzapine (Zyprexa) tablet; 5 mg, 1 tablet, oral, once a day for diagnosis of physiological condition with mixed features. Review of Resident #60's pharmacy reviews from January 2025 to August 2025 revealed there had not been an attempt to do a gradual dose reduction for the order for Zyprexa. Interview on 8/30/25 at 5:45 PM with the ADON revealed she was responsible for tracking the pharmacy reviews and to monitor GDRs for psychotropic medications. The ADON stated Resident #60 had been taking Zyprexa, an antipsychotic medication since 1/4/24 per psychiatric group. Upon reviewing Resident #60's medical chart, the ADON stated a gradual dose reduction had not been attempted. The ADON stated Resident #60 was on Hospice services and they had decided to continue Resident #60 on the medication. The ADON stated the facility and Hospice services were to coordinate services and further stated she had not discussed a gradual dose reduction with the Hospice nurse. The ADON stated the purpose of a gradual dose reduction was to reduce or eliminate the medication altogether if possible. She stated some of the side effects for prolonged use could include Tardive Dyskinesia, (twitching body parts), tremors, weight loss and neurological side effects. Review of a facility policy, Behavior Management - Psychoactive Medication - Antipsychotic Drug Therapy, dated 12/2017, read in relevant part Policy It is the policy of this home to use antipsychotic medications per CMS guidelines and to perform dose reductions and monitoring as required by regulation, to promote the highest level of resident care and safety. Definitions 1. A gradual dose reduction is a tapering of the resident's daily dose to determine if the resident's symptoms can be controlled by a lower dose or to determine if the dose can be eliminated altogether.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews in response to allegations of abuse, neglect, exploitation, or mistreatment, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, were reported not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency) in accordance with State law through established procedures, for 2 of 8 residents (Residents #9 and #63) reviewed for allegations of neglect. 1. Resident #9 was observed with her own smoking paraphernalia which included a lighter (a self-contained ignition source used to light cigarettes) and was observed smoking on the facility property without supervision and or at the assigned agreed upon times for supervised smoking.2. Resident #63 was discovered with smoking paraphernalia which included a lighter and cigarettes, and was actively smoking, while receiving oxygen therapy, in his bathroom, twice once on 8/12/2025 and again on 8/21/2025. These failures could place residents at risk of harm.The findings included: 1. A record review of the Texas Unified Licensure Information Portal (TULIP) for the time May 1st, 2025, through August 30th, 2025, revealed no evidence of a report to the state agency for the smoking incidents for Resident #9 on 6/12/2025 and again on 6/15/2025. A record review of Resident #9's admission record, dated 8/29/2025, revealed an admission date of 6/2/2025 and a discharge date of 8/27/2025 with diagnoses which included chronic obstructive pulmonary disease (COPD, a group of lung diseases that cause airflow obstruction and breathing difficulties), left lower leg amputation, intermittent explosive disorder (recurrent episodes of impulsive, aggressive, and violent behavior that is disproportionate to the triggering situation), and diabetes mellitus II (a chronic condition where the body does not use insulin effectively or does not produce enough insulin and results in high concentrations of sugars in the bloodstream with potential negative outcomes). A record review of Resident #9's quarterly MDS dated [DATE] revealed resident #9 was a [AGE] year-old female admitted for long term care with supports for safe supervised smoking. Resident was assessed with a BIMS score of 15 out of 15 which indicated no cognitive impairment. A record review of Resident #9's care plan dated 8/27/2025 revealed, problem: resident is a smoker . instruct resident about smoking risks and hazards and about smoking cessation aids that are available . instruct resident about the facility policy on smoking locations, times, safety concerns, . notify charge nurse immediately if it is suspected resident has violated facility smoking policy . observe clothing and skin for signs of cigarette burns . A record review of Resident #9's nursing progress notes revealed on 6/13/2025 at 4:16 AM, LVN F documented, patient noted going into (another resident's) room multiple times throughout the night and taking patient out to smoke. A record review of Resident #9's nursing progress notes revealed on 6/15/2025 at 11:47 AM, LVN X documented, resident observed outside in courtyard smoking with another resident, resident was redirected. When nurse asked for lighter and cigarette, resident refused and stated she could smoke outside. Resident nurse notified. During an interview on 8/30/2025 at 1:51 PM, LVN F stated Resident #9 would often smoke unsupervised and at unassigned time. LVN F stated Resident #9 often had her own cigarettes and lighter and would surrender the lighter when asked but would often obtain another lighter, most likely from when she would sign herself out on pass. smoked out in the courtyard unsupervised and reported to the ADON and previous DON stated risk for burns LVN F stated he recalled his documentation on 6/12/2025 at 4:00 a.m. when he observed Resident #9 in the facility courtyard smoking cigarettes. LVN F stated he reported the incident at the change of shift to the previous DON and the ADON. During an interview on 8/30/2025 at 2:01 PM, the ADON stated she had not received a report from LVN F regarding Resident #9's possession of smoking paraphernalia and unsupervised smoking. The ADON stated the routine for facility IDT was to meet daily and review the previous days incidents which included a review of the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nursing progress notes. The ADON stated she could not recall the IDT morning meeting on 6/13/2025 and 6/16/2025 which could have revealed the smoking incidents for Resident #9. The ADON stated the smoking incidents were not reported to the state agency and the decision to report would be made by the IDT team and by the Administrator. 2. A record review of the Texas Unified Licensure Information Portal (TULIP) for the time May 1st, 2025, through August 30th, 2025, revealed no evidence of a report to the state agency for the smoking incidents for Resident #63 on 8/12/2025 and again on 8/21/2025. Record review of Resident #63's admission record dated 8/30/2025 revealed an admission date of 5/14/2025 with diagnoses which included malnutrition, anxiety, pain, hypertension (high blood pressure), muscle spasms / weakness, reflux, and chronic obstructive pulmonary disease. A record review of Resident #63 quarterly MDS, dated [DATE], revealed Resident #63 was a [AGE] year-old male admitted for long term care with supports for safe supervised smoking. Resident #63 was assessed with a BIMS score of 11 out of a possible 15 which indicated moderate cognitive impairment. A record review of Resident #63's physicians order, dated 5/14/2025, revealed the physician prescribed for Resident #63 to receive continuous oxygen therapy every shift every day and night. Record review of Resident #63's care plan, dated 8/30/2025, revealed he was an intermittent smoker (start date 5/14/2025) with a revision on 8/12/2025 indicating he was noncompliant with the smoking policy and smoking in his bathroom and was educated/acknowledged smoking agreement. A record review of the facility's event report, dated 8/12/2025, revealed at 4:00 PM the Social Worker and LVN A discovered Resident #63 in his bathroom smoking while receiving oxygen therapy via a nasal cannula and an oxygen concentrator. A record review of the facility's event report, dated 8/21/2025, revealed at an unknown time prior to 4:00 PM LVN A and CNA B discovered Resident #63 was in his bathroom smoking while receiving oxygen therapy via a nasal cannula and an oxygen concentrator. During an observation and interview on 8/28/2025 at 1:40 PM, revealed Resident #63 was in his room and was assisted to pack and gather his belongings to discharge to another facility. Resident #63 stated he was discharged related to his episodes of smoking in his room's bathroom. Resident #63 stated he did not participate in the supervised assigned smoke breaks due to his inability to participate in the smoke break without his oxygen therapy. Resident #63 stated he could not endure very long without his oxygen because of his COPD. During an interview on 8/28/2025 at 1:50 PM, LVN A stated she and the SW discovered Resident #63 smoking in his bathroom twice in August 2025. LVN A stated the ADON, the DON, and the Administrator were aware of Resident #63's smoking incidents. LVN A stated Resident #63's smoking had serious injury potential to include fires and/or burns. During an interview on 8/28/2025 at 4:10 PM, the ADON stated she was aware of Resident #63's smoking incidents while he was on oxygen therapy and had reviewed the incidents in the morning IDT meetings with the DON and the Administrator and could not recall anyone discussing a report to the state agency for the incidents. During an interview on 8/28/2025 at 5:00 PM, the Administrator stated she had received a report from nursing staff that Resident #9 and Resident #63 had a history of smoking unsupervised and at unassigned times. The Administrator stated LVN A and the SW reported that Resident #63 had been caught smoking in his bathroom on 8/12/2025 and again on 8/21/2025. The Administrator stated the facility could no longer meet Resident #63's and Resident #9's needs for safe smoking and non-compliant behavior and discharged the residents. The Administrator stated the IDT and herself had not considered the incidents as incidents which were reportable to the state agency and had not reported the incidents to the state agency. During an interview on 8/29/2025 at 4:40 PM, NP C stated he was the NP for the MD and was responsible for Resident #63's medical care. NP C stated Resident #63 had a need for oxygen therapy related to his poor gas exchange and should never be able to smoke while receiving oxygen therapy. NP C stated the practice was dangerous not only to Resident #63 but to the public to include a potential for fires and explosions. A record review of the facility's smoking policy dated 2017 revealed, It is the policy of this home that: All residents who smoke will be supervised. Smoking will be permitted in designated safe area(s) only. Oxygen equipment is not permitted in. the smoking area(s). The minimum safe (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	distance for oxygen equipment from the smoking area is 50 feet. Residents not complying with the home's smoking policy may be discharged from the home.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455713	A. Building B. Wing	08/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at San Antonio	50 Briggs Ave. San Antonio, TX 78224

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure based on the comprehensive assessment of a resident, that residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for 2 of 16 residents (Resident #91 and Resident #106) whose records were reviewed for quality of care. 1. Facility staff failed to identify, respond, and act upon Resident #91's critical lab, glucose (blood sugar) level of 40 received on 8/14/25. 2. Facility staff failed to follow Resident #106's transferring physicians orders for eye patch/assistance, monitoring for potential adverse reactions to medications, and his physician's prescribed lab orders. These deficient practices could affect any resident and could contribute to the decline of the resident's health statuses. The findings were: 1. Record review of Resident #91's face sheet, dated 8/28/25, revealed he was admitted to the facility on [DATE] with diagnoses including Type 2 diabetes mellitus (the body cannot use insulin correctly and sugar builds up in the blood) without complications and Major depressive disorder, recurrent, mild (pervasive low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities). Record review of Resident #91's admission MDS assessment, dated 7/28/25, revealed his BIMS score was 13 of 15 reflective of minimal cognitive impairment, diagnosis of diabetes mellitus and it reflected he received insulin injections on a regular basis. Record review of Resident #91's Care Plan, dated 7/29/28, revealed it did not reflect that he had diabetes mellitus or that he was receiving insulin injections. Record review of Resident #91's physician orders for July and August 2025 revealed an order which reflected to call MD if his blood sugar level was under 70. Record review of Resident #91's lab report, dated 8/13/25, revealed LVN W received a call from the lab company at about 2:30 AM on 8/13/25. The lab results revealed a critical lab, glucose (blood sugar), level of 40. Record review of Resident #91's nursing progress note, dated 8/13/25, revealed the last entry was made at 10:00 which reflected he was on antibiotic treatment, Levaquin, for UTI. Record review of Resident #91's meal intake document for 8/13/25 revealed he ate 75% of his breakfast and 50% of his lunch and dinner. Further review revealed the document did not reflect whether or not he had a PM snack. Record review of a progress notes dated 8/14/25 revealed the only AM entry was at 0900. There were no other entries. Record review of Resident #91's monitoring flowsheet for August 2025 revealed an order, vital signs monitoring, Other test. Every shift 07/23/25 - Open Ended. Further review of the flowsheet revealed Resident #91's vital signs for the night shift on 8/13/25 were: temperature 97, pulse 88, respirations 18, blood pressure 140/70 and 02 saturation was 98. The monitoring flowsheet did not reflect a time the vitals were taken. Record review of Resident #91's Diabetic flowsheet from 8/1/25 to 8/31/25 revealed an order for Humalog U-100 Insulin (insulin lispro) solution; 100 unit/mL; 6 units, subcutaneous, Other Test: Before (continued on next page)

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Avir at San Antonio	50 Briggs Ave. San Antonio, TX 78224

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Meals administer 6 units before meals in addition to sliding scale for Type 2 diabetes mellitus without complications. The document reflected he received 3 doses per physician orders on 8/13/25. Further review revealed a sliding scale order for insulin lispro, insulin pen; 100 unit/mL If blood sugar is less than 70, call MD. If blood sugar is 71 to 150, give 0 units. The document reflected his blood sugar at 2100 (9:00 PM) was 117 and he did not receive Insulin lispro. Record review of the nursing facility staffing schedule for 8/13/25 revealed LVN W was scheduled to work from 7:00 PM to 7:00 AM. Observation and interview on 8/27/25 at 12:32 PM revealed Resident #91 lying in bed. He stated his left shoulder and hip hurt related to a fall he had prior to coming to the facility. Interview on 8/29/25 at 5:10 PM with Resident #91's NP C, revealed he did not receive a phone call during the early morning on 8/13/25 related to Resident #91's critical blood sugar level of 40. He stated to date, nursing staff had not called him about it. He stated he was familiar with LVN W and stated he checked his phone log and did not receive a call from the facility on 8/13/25. He stated he would have expected LVN W to call him and inform him of Resident #91's critical lab results (change of condition). NP C stated he would have asked LVN W to assess Resident #91, to take vitals and an Accu-Chek (check his blood sugar level). He stated he would have asked about Resident #91's blood sugar levels throughout the day and night on 8/13/25 up until LVN W received the call from the lab company. He would have asked about Resident #91's insulin administration for the same time frame. NP C stated this would provide him with the information he needed to provide a new order as necessary. Interview on 8/29/25 at 5:53 PM with LVN W revealed he stated he worked on 8/13/25 from 7:00 PM to 7:00 AM. LVN W stated he remembered Resident #91 and understood his condition was very complex. He stated he could not recall receiving a call from the lab company about a critical blood sugar level of 40. He stated in this situation he would be expected to complete an SBAR for a change in condition to include vital signs. He stated for a critical lab blood sugar level of 40 he would expect NP C to ask him for Resident #91's vitals, possibly ask for Accu-Chek to determine current blood sugar level, provide information about his blood sugar values throughout the day, meal intake and insulin received. LVN W further stated he would be expected to call the ADON, DON and Resident #91's responsible party. LVN W again stated he did not recall any events which occurred on 8/13/25 related to Resident #91's critical lab report. Observation and interview on 8/30/25 at 5:45 PM with the ADON revealed she could not remember receiving a call from LVN W regarding Resident #91's critical blood sugar level of 40, dated 8/13/25. She stated she did not remember the topic coming up during the morning meeting on 8/14/25 based on 24-hour report. Observation of the ADON revealed she reviewed Resident #91's lab report, dated 8/13/25 and nurse's progress notes dated 8/13/25 to 8/14/25. The ADON stated she became aware of the critical lab upon Surveyor intervention. The ADON stated LVN W should have called the NP, her, the DON, the RP and followed any new orders; completed an SBAR and progress note reflecting the critical lab, blood sugar level of 40. She stated she did not see any documentation that reflected LVN W took any action related to the critical lab value. The ADON stated it was important to take immediate action anytime there was a change in a resident's condition to ensure the resident received the necessary treatment. Otherwise, the resident could experience a decline in condition and even death. Interview on 8/30/25 at 6:05 PM with the DON revealed she was not aware that a critical lab, blood (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sugar level of 40 was received regarding Resident #91 until Surveyor intervention. The DON stated she expected a nurse to take immediate action when a resident had a changed of condition to include assessing the resident, calling the PCP/NP, the RP, her and the ADON and follow any new orders. She stated it was critical that a resident received the necessary care as needed so the resident did not have a decline in their health. Review of facility policy titled, Nursing Policy and Procedure, Change of Condition-Observing Reporting and Recording, dated 12/2017 read in relevant part: It is the policy of this home to inform the resident, the resident's physician and if indicated the residents responsible party of the following. 2. A significant change in the resident's physical, mental or psychosocial status, such as a deterioration in health, mental or psychosocial status, in life-threatening conditions or clinical complications. Procedure Observing, Reporting and Documenting a Change in Condition: 1. After resident changes in condition including but not limited to falls, injuries, changes in health and psychosocial status conduct a thorough assessment and compare against baseline. 2. Do not leave the resident alone when a change in condition is identified until the licensed nurse has determined that the resident is not in danger in any way related to their medical or mental changes in condition. 3. The attending physician should be notified as soon as possible if immediate attention is required or as soon as feasible if the resident is stable (change inn condition is resolved such as a fall without injury or head trauma). 4. Complete an incident/accident report if indicated (fall, injury etc.). 5. Notify resident's responsible party. 6. If necessary, due to the seriousness of the change in condition or as ordered by the physician, transfer the resident to the hospital by ambulance or appropriate transportation. 2. A record review of Resident #106's admission record dated 8/1/2025 revealed Resident #106 was a [AGE] year-old male admitted for LTC with an admission date of 8/15/2025 and diagnoses which included legal blindness, generalized anxiety disorder, and seizures. A record review of Resident #106's transfer discharge report dated 8/15/2025 revealed Resident #106 was transferred to the facility from a previous SNF on 8/15/2025. Resident #106 was prescribed by the physician to receive: - yearly labs to include a lipid panel and a valproic acid lab. - adverse effects monitoring for: - antidepression medications. - antianxiety medications. - anticonvulsant medications. -assistance with wearing an eye patch to his left eye to strengthen his right eye. A record review of Resident #106's physicians orders dated 8/17/2025 revealed no orders for Resident #106's eye patch, medication monitoring for adverse effects, and or labs needed. During an interview on 8/27/2025 at 11:10 AM LVN MG stated Resident #106 had no orders for adverse drug reaction monitoring, no order for an eye patch, and no orders for labs. LVN MG stated she was the admitting nurse for Resident #106 when he transferred from the previous SNF and had (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reviewed his transfer documents to include previous orders and had failed to recognize the orders for Resident #106's eye patch, labs, or monitoring for adverse effects from hiss medications. LVN MG stated she had no recollection on how she failed to transcribe the orders and stated she would immediately assess Resident #106 and report to the physician and recommend labs, monitoring, and an eye patch. LVN MG stated her supervisor was the ADON and the DON. During an interview on 8/27/2025 at 11:50 AM the ADON stated Resident #106 did not have any orders for labs, monitoring for adverse effects of medications, and no eye patch. The ADON stated the expectation for admission nurses was a thorough and complete review of the admission records and transcription of all orders for transition of care. During an interview on 8/28/2025 at 1:09 PM Resident #106 stated he was transferred to this facility from a previous SNF, and he was legally blind but had partial sight to see shapes and some colors. Resident #106 stated he could see better out of one eye and had used an eye patch over one of his eyes in the past. Resident #106 stated he had not used an eyepatch while at this facility. During an interview on 8/30/2025 at 1:00 PM NP C stated he was the NP for Resident #106 and was unaware Resident #106 had a need for an eye patch, lab work, and or monitoring for adverse effects for medications he was receiving. NP C stated he would expect for the admission nurse to completely review and report to the physician all orders from the previous SNF for continuation of care. NP C stated a potential negative outcome could be delay of care. A quality-of-care policy was requested from the Administrator on 8/30/2025 at 7:52 PM to which the Administrator replied, the facility followed HHSC guidelines.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to promptly notify the ordering physician of laboratory results that fell outside of clinical reference ranges for 1 (Resident #91) of 16 residents whose medical records were reviewed for lab work. Facility staff failed to identify, respond, and act upon Resident #91's critical lab, glucose (blood sugar) level of 40 received on 8/14/25. This deficient practice could affect any resident and could contribute to the decline of the resident's health statuses. The findings were:Record review of Resident #91's face sheet, dated 8/28/25, revealed he was admitted to the facility on [DATE] with diagnoses including Type 2 diabetes mellitus (the body cannot use insulin correctly and sugar builds up in the blood) without complications and Major depressive disorder, recurrent, mild (pervasive low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities). Record review of Resident #91's admission MDS assessment, dated 7/28/25, revealed his BIMS score was 13 of 15 reflective of minimal cognitive impairment, diagnosis of diabetes mellitus and it reflected he received insulin injections on a regular basis. Record review of Resident #91's Care Plan, dated 7/29/28, revealed it did not reflect that he had diabetes mellitus or that he was receiving insulin injections. Record review of Resident #91's physician orders for July and August 2025 revealed an order which reflected to call MD if his blood sugar level was under 70. Record review of Resident #91's lab report, dated 8/13/25, revealed LVN W received a call from the lab company at about 2:30 AM on 8/13/25. The lab results revealed a critical lab, glucose (blood sugar), level of 40. Record review of Resident #91's nursing progress note, dated 8/13/25, revealed the last entry was made at 10:00 which reflected he was on antibiotic treatment, Levaquin, for UTI. Record review of Resident #91's meal intake document for 8/13/25 revealed he ate 75% of his breakfast and 50% of his lunch and dinner. Further review revealed the document did not reflect whether or not he had a PM snack. Record review of a progress notes dated 8/14/25 revealed the only AM entry was at 0900. There were no other entries. Record review of Resident #91's monitoring flowsheet for August 2025 revealed an order, vital signs monitoring, Other test. Every shift 07/23/25 - Open Ended. Further review of the flowsheet revealed Resident #91's vital signs for the night shift on 8/13/25 were: temperature 97, pulse 88, respirations 18, blood pressure 140/70 and 02 saturation was 98. The monitoring flowsheet did not reflect a time the vitals were taken. Record review of Resident #91's Diabetic flowsheet from 8/1/25 to 8/31/25 revealed an order for Humalog U-100 Insulin (insulin lispro) solution; 100 unit/mL; 6 units, subcutaneous, Other Test: Before Meals administer 6 units before meals in addition to sliding scale for Type 2 diabetes mellitus without complications. The document reflected he received 3 doses per physician orders on 8/13/25. Further review revealed a sliding scale order for insulin lispro, insulin pen; 100 unit/mL If blood sugar is less than 70, call MD. If blood sugar is 71 to 150, give 0 units. The document reflected his blood sugar at 2100 (9:00 PM) was 117 and he did not receive Insulin lispro. Record review of the nursing facility staffing schedule for 8/13/25 revealed LVN W was scheduled to work from 7:00 PM to 7:00 AM. Observation and interview on 8/27/25 at 12:32 PM revealed Resident #91 lying in bed. He stated his left shoulder and hip hurt related to a fall he had prior to coming to the facility. Interview on 8/29/25 at 5:10 PM with Resident #91's NP C, revealed he did not receive a phone call during the early morning on 8/13/25 related to Resident #91's critical blood sugar level of 40. He stated to date, nursing staff had not called him about it. He stated he was familiar with LVN W and stated he checked his phone log and did not receive a call from the facility on 8/13/25. He stated he would have expected LVN W to call him and inform him of Resident #91's critical lab results (change of condition). NP C stated he would have asked LVN W to assess Resident #91, to take vitals and an Accu-Chek (check his blood sugar level). He stated he would have asked about Resident #91's blood sugar levels throughout the day and night on 8/13/25 up until LVN W received the call from the lab company. He would have (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	asked about Resident #91's insulin administration for the same time frame. NP C stated this would provide him with the information he needed to provide a new order as necessary. Interview on 8/29/25 at 5:53 PM with LVN W revealed he stated he worked on 8/13/25 from 7:00 PM to 7:00 AM. LVN W stated he remembered Resident #91 and understood his condition was very complex. He stated he could not recall receiving a call from the lab company about a critical blood sugar level of 40. He stated in this situation he would be expected to complete an SBAR for a change in condition to include vital signs. He stated for a critical lab blood sugar level of 40 he would expect NP C to ask him for Resident #91's vitals, possibly ask for Accu-Chek to determine current blood sugar level, provide information about his blood sugar values throughout the day, meal intake and insulin received. LVN W further stated he would be expected to call the ADON, DON and Resident #91's responsible party. LVN W again stated he did not recall any events which occurred on 8/13/25 related to Resident #91's critical lab report. Observation and interview on 8/30/25 at 5:45 PM with the ADON revealed she could not remember receiving a call from LVN W regarding Resident #91's critical blood sugar level of 40, dated 8/13/25. She stated she did not remember the topic coming up during the morning meeting on 8/14/25 based on 24-hour report. Observation of the ADON revealed she reviewed Resident #91's lab report, dated 8/13/25 and nurse's progress notes dated 8/13/25 to 8/14/25. The ADON stated she became aware of the critical lab upon Surveyor intervention. The ADON stated LVN W should have called the NP, her, the DON, the RP and followed any new orders; completed an SBAR and progress note reflecting the critical lab, blood sugar level of 40. She stated she did not see any documentation that reflected LVN W took any action related to the critical lab value. The ADON stated it was important to take immediate action anytime there was a change in a resident's condition to ensure the resident received the necessary treatment. Otherwise, the resident could experience a decline in condition and even death. Interview on 8/30/25 at 6:05 PM with the DON revealed she was not aware that a critical lab, blood sugar level of 40 was received regarding Resident #91 until Surveyor intervention. The DON stated she expected a nurse to take immediate action when a resident had a changed of condition to include assessing the resident, calling the PCP/NP, the RP, her and the ADON and follow any new orders. She stated it was critical that a resident received the necessary care as needed so the resident did not have a decline in their health. Review of facility policy titled, Nursing Policy and Procedure, Change of Condition-Observing Reporting and Recording, dated 12/2017 read in relevant part: It is the policy of this home to inform the resident, the resident's physician and if indicated the residents responsible party of the following. 2. A significant change in the resident's physical, mental or psychosocial status, such as a deterioration in health, mental or psychosocial status, in life-threatening conditions or clinical complications. Procedure Observing, Reporting and Documenting a Change in Condition: 1. After resident changes in condition including but not limited to falls, injuries, changes in health and psychosocial status conduct a thorough assessment and compare against baseline. 2. Do not leave the resident alone when a change in condition is identified until the licensed nurse has determined that the resident is not in danger in any way related to their medical or mental changes in condition. 3. The attending physician should be notified as soon as possible if immediate attention is required or as soon as feasible if the resident is stable (change inn condition is resolved such as a fall without injury or head trauma). 4. Complete an incident/accident report if indicated (fall, injury etc.). 5. Notify resident's responsible party. 6. If necessary, due to the seriousness of the change in condition or as ordered by the physician, transfer the resident to the hospital by ambulance or appropriate transportation.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation and interview the facility failed to dispose of garbage and refuse properly for 1 of 1 dumpster reviewed for disposal of garbage. The facility's dumpster presented with 1 30-gallon bag of trash besides the garbage dumpster and scattered garbage surrounding the dumpster area. This failure could place residents at risk for reduced health status and degraded morale. The findings included: During an observation on 8/28/2025 at 10:13 AM revealed the facility's dumpster concrete pad had a large steel dumpster with the sliding doors opened. Further observation revealed a 30-gallon plastic bag filled with garbage on the concrete besides the dumpster. Further review revealed scattered trash surrounding the dumpster. During an interview on 8/28/2025 at 10:22 AM the HK manager stated the dumpster was utilized by the dietary staff, nursing staff, and the housekeeping staff. The HK manager stated the expectation for the staff was for all trash to be placed in the dumpster and for the dumpster doors to be closed when not in use. The HK manager stated the surrounding area should be cleaned to have all the trash placed in the dumpster. The HK manager stated the potential risk for residents could be reduced morale. A trash dumpster policy was requested from the Administrator on 8/30/2025 at 7:52 PM to which the Administrator replied, the facility followed HHSC guidelines.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to immediately consult with the resident's physician when there was a significant change in the resident's physical status (that is, a deterioration in health status, (status in either life-threatening conditions or clinical complications) for 1 of 6 Residents (Resident #91) whose records were reviewed. LVN W failed to notify Resident #91's physician on 8/14/25 when he received a critical lab reflecting Resident #91's blood sugar was 40. This deficient practice could place residents at risk for a delay in treatment and a decline in the resident's physical condition. The findings were:Review of Resident #91's face sheet, dated 8/28/25, revealed he was admitted to the facility on [DATE] with diagnoses including Type 2 diabetes mellitus (the body cannot use insulin correctly and sugar builds up in the blood) without complications and Major depressive disorder, recurrent, mild (pervasive low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities). Review of Resident #91's admission MDS assessment, dated 7/28/25, revealed his BIMS score was 13 of 15 reflective of minimal cognitive impairment, diagnosis of diabetes mellitus and it reflected he received insulin injections on a regular basis. Review of Resident #91's Care Plan, dated 7/29/28, revealed it did not reflect that he had diabetes mellitus or that he received insulin injections. Review of the nursing facility staffing schedule for 8/13/25 revealed LVN W was scheduled to work from 7:00 PM to 7:00 AM. Review of Resident #91's lab report, dated 8/13/25, revealed LVN W received a call from the lab company at about 2:30 AM on 8/13/25. The lab results revealed a critical lab, glucose (blood sugar), level of 40. Review of Resident #91's nursing progress note, dated 8/13/25, revealed the last entry was made at 10:00 which reflected he was on antibiotic treatment, Levaquin, for UTI. Review of a progress note dated 8/14/25 revealed the first entry was at 0900 AM and it reflected Resident #91 continued on antibiotic treatment, Levaquin, for diagnosis of UTI. Further review revealed there were no progress notes entered between 8/13/25 at 2:30 AM and 8/14/25 at 10:00. Interview on 8/29/25 at 5:10 PM with Resident #91's NP C, stated he did not receive a phone call from the facility during the early morning of 8/13/25. He stated he was familiar with LVN W and stated he checked his phone log and did not receive a call from LVN W. NP C stated he would have expected LVN W to call him and inform him of Resident #91's critical lab results (change of condition). NP C stated he would have expected LVN W to have assessed Resident #91 and to do an Accu-Chek (check his blood sugar level) and provide him with a report. He stated he would have asked about Resident #91's blood sugar levels throughout the day and night on 8/13/25 up until LVN W received the call from the lab company. He stated he would have asked about Resident #91's insulin administration for the same time frame. NP C stated this would provide him with the information needed to provide a new order as necessary. Interview on 8/29/25 at 5:53 PM with LVN W stated he worked on 8/13/25 from 7:00 PM to 7:00 AM. LVN W stated he remembered Resident #91 but could not recall receiving a call from the lab company about a critical blood sugar level of 40. He stated he was expected to complete an SBAR anytime there was a change in a resident's condition. He stated for a critical lab, blood sugar level of 40 he would be expected to call the NP, to assess the resident, possibly check his blood sugar level, provide the NP with the resident's blood sugar values throughout the day, meal intake and insulin received. LVN W further stated he was also required to call the ADON or DON and Resident #91's responsible party. LVN W again stated he did not recall any events which occurred on 8/13/25 related to Resident #91. Interview on 8/30/25 at 5:45 PM with the ADON revealed she could not remember receiving a call from LVN W regarding Resident #91's critical lab related to his blood sugar level of 40, dated 8/13/25. She stated she did not remember the topic coming up during the morning meeting on 8/14/25. The ADON reviewed Resident #91's lab report, dated 8/13/25 and nurse's progress notes dated 8/13/25 to 8/14/25. The ADON stated LVN W should have called the NP, her, the DON, the RP and followed (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	any new orders; completed an SBAR and progress note reflecting the critical lab, blood sugar level of 40. The ADON stated it was important to immediately take action anytime there was a change in a resident's condition to ensure the resident received the necessary treatment, otherwise, the resident could experience a decline in condition. The ADON stated she did not see any evidence to reflect LVN W took any action related to Resident #91. Interview on 8/30/25 at 6:05 PM with the DON revealed she was not aware that a critical lab, blood sugar level of 40 was received regarding Resident #91. The DON stated she expected a nurse to take immediate action when a resident had a change of condition to include assessing the resident, calling the PCP/NP, the RP, her and or the ADON and follow any new orders. She stated it was critical that a resident received the necessary care as needed so the resident did not have a decline in their health. Review of facility policy titled, Nursing Policy and Procedure, Change of Condition-Observing Reporting and Recording, dated 12/2017 read in relevant part: It is the policy of this home to inform the resident, the resident's physician and if indicated the residents responsible party of the following. 2. A significant change in the resident's physical, mental or psychosocial status, such as a deterioration in health, mental or psychosocial status, in life-threatening conditions or clinical complications. Procedure Observing, Reporting and Documenting a Change in Condition: 1. After resident changes in condition including but not limited to falls, injuries, changes in health and psychosocial status conduct a thorough assessment and compare against baseline. 2. Do not leave the resident alone when a change in condition is identified until the licensed nurse has determined that the resident is not in danger in any way related to their medical or mental changes in condition. 3. The attending physician should be notified as soon as possible if immediate attention is required or as soon as feasible if the resident is stable (change inn condition is resolved such as a fall without injury or head trauma). 4. Complete an incident/accident report if indicated (fall, injury etc.). 5. Notify resident's responsible party. 6. If necessary, due to the seriousness of the change in condition or as ordered by the physician, transfer the resident to the hospital by ambulance or appropriate transportation.

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Avir at San Antonio	50 Briggs Ave. San Antonio, TX 78224

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the assessment accurately reflected the resident's status for 1 of 6 Residents (Resident #76) whose MDS records were reviewed.MDS Coordinator/LVN T failed to include in Resident #76's MDS assessment that she had lost weight in the last 6 months. This deficient practice could place residents at risk of not receiving the care and services as needed.The findings were:Record review of Resident #76's face sheet, dated 8/30/25, revealed she was admitted to the facility on [DATE] with diagnoses including muscle weakness (generalized), unsteadiness on feet and other lack of coordination. Record review of Resident #76's quarterly MDS, dated [DATE], revealed her BIMS score was 12 of 15 reflective of moderate cognitive impairment and she was dependent on staff for all ADL's. Further review revealed it did not reflect she had lost weight during July 2025. Record review of Resident #76's Care Plan, dated 7/16/25, revealed she had a significant unplanned/unexpected weight loss due to poor food intake. Observation and interview on 08/26/25 at 12:34 PM revealed Resident #76 eating her lunch meal. She stated she did not like the food and had a family member bring her take out. Interview on 08/30/2025 at 4:40 PM the MDS Coordinator/LVN T stated it was important that Resident #76's MDS assessment accurately reflect her status, so everyone was on the same page in regard to identified problems, goals and approaches to help Resident #76 manage her weight loss. LVN T stated otherwise staff would not know what interventions to implement. She stated as a result Resident #76 could lose more weight. Further interview with LVN T revealed she used the RAI as a policy for completing MDS assessments.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care within 48 hours of a resident's admission and failed to include the minimum healthcare information necessary to properly care for a resident including, but not limited to, initial goals based on admission and physician orders for 1 of 6 residents (Resident #104), reviewed for comprehensive resident centered care plans. Resident #104's baseline care plan dated 8/23/25 did not include her diagnoses, contact isolation for MRSA (Methicillin-resistant Staphylococcus Aureus bacteria) to her wound, and did not have interventions and goals for 5 of 5 days during the survey period. This failure could place residents at risk of not receiving their individualized needed care and services.The findings were: Record review of the facility documentation for Resident #104 revealed there was no face sheet for Resident #104. Record review of Resident #104's admission assessment dated [DATE] revealed the resident was a female admitted by ambulance on a stretcher on 8/22/25 at 11:53 p.m. and had only 1 diagnosis listed osteomyelitis (inflammation of the bone caused by an infection, which may spread to the bone marrow and tissues near the bone). The resident had a right above knee amputation with 29 staples, a sacral wound, and a left lower extremity wound, and the resident had an indwelling foley catheter. Record review of Resident #104's information in IQIES on 8/27/25 and 9/3/25 at 8:50 a.m., revealed no information found for the resident's MDS assessment due to being a new admission. Record review of Resident #104's admission care plan, dated 8/23/25, was a paper with check boxes next to different body systems and revealed the resident was [AGE] years old, and under bladder control the box was checked for incontinent and catheter was not checked. Under special problems affecting ADL decubitus(skin breakdown that occurs when prolonged pressure on the same area of the body cuts off blood flow and oxygen to the tissues)/stasis ulcers (open sore that develops on the lower legs due to poor blood circulation) was checked and handwritten next to it was sacral (anatomical region of the body located at the base of the spine, just above the buttocks)/LLE (Left Lower Extremity), and amputations was checked and handwritten next to it was July 2025. Under rehabilitation measures/programs the box intake/output was checked, and output was circled, wound dressing was checked, and decubitus/stasis ulcers was checked. All lines next to the boxes with check marks under this rehabilitation measures/programs section were blank. There was a second page to the admission care plan that had 3 columns and was blank. Record review of Resident #104's weekly skin assessment dated [DATE], and handwritten next to the date was on admission revealed under skin findings was 27 staples to R BKA (Right Below knee Amputation), left heel pressure and pressure had been marked through and written arterial- eschar (thick, black, dead tissue), left anterior foot arterial eschar, stage 4 to sacrum/coccyx pressure, and stage 3 to right buttock. The skin assessment continued with wound measurements and boxes checked for vitamin C, protein supplement, multivitamin, zinc, pillows to float heels, and an air mattress with the physician being notified on 8/23/25 at 8:00 a.m. The skin assessment is signed 8/26/25 at 10:00 a.m. and unable to make out the signature. Review of Resident #104's physician telephone orders revealed orders dated 8/23/25 at 8:00 a.m. for catheter care every shift and as needed, 16 FR 10cc foley change as needed, ensure foley was secured with anchor and draining below bladder, and contact precautions, and wound dressing orders for left heel, sacral wound, left anterior ankle, and right buttock and skin assessments weekly on Saturday night shift. Record review of Resident #104's hospital discharge paperwork dated 8/19/25 to 8/22/25 revealed the resident had bilateral heel osteomyelitis, constipation, MRSA to sacral wound, Right AKA on 7/21/25, and diabetes mellitus (a disease of inadequate control of blood levels of glucose), and was bed bound (confined to bed). Record review of (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #104's history and physical, dated 8/25/25, revealed the resident's past medical history included stroke with residual right sided deficit (refers to damage to tissues in the brain due to a loss of oxygen to the area resulting in weakness and loss of strength on one side of the body), bed bound status (confined to her bed), bowel and bladder incontinence, history of pulmonary embolism (occurs when a blood clot travels to the lungs and blocks one or more pulmonary arteries), asthma (a chronic respiratory condition that causes inflammation and narrowing of the airways, leading to symptoms such as wheezing, shortness of breath, and chest tightness), Type 2 diabetes mellitus (a chronic condition in which the body does not use insulin effectively or does not produce enough insulin to regulate blood sugar levels), hyperlipidemia (high levels of lipids (fats) in the blood, including cholesterol and triglycerides), sacral pressure ulcer, acute respiratory failure (life-threatening condition where the lungs cannot adequately exchange oxygen and carbon dioxide), pneumonia (infection of one or both of the lungs caused by bacteria, viruses, or fungi), and anemia (not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues). Record review of Resident #104's history and physical, dated 8/25/25, revealed under assessment and plan was documented continue to monitor respiratory status, maintain adequate oxygenation, pulmonary rehabilitation as tolerated, continue physical therapy for strengthening and mobility, occupational therapy for ADL training, monitor surgical site for proper healing, pain management as needed, continue appropriate antibiotic therapy, monitor for signs of infection progression, wound care as directed, specialized wound care per protocol, regular repositioning to prevent further pressure injury, nutritional support to promote wound healing, monitor for signs of infection, monitor hemoglobin and hematocrit levels, nutritional support with iron rich diet, neurological monitoring, continue insulin sliding scale, diabetic diet, regular glucose monitoring, continue medication for hyperlipidemia, monitor lipid levels periodically, monitor for signs and symptoms of DVT/PE (Deep Vein Thrombosis/Pulmonary Embolism), monitor for constipation and implement bowel regimen as needed. Record review of Resident 104's hospital transfer form and telephone orders, dated 8/22/25, revealed the resident was a full code. Record review of Resident 104's baseline care plan, dated 8/23/25, did not include the resident's code status, diagnoses, MRSA of her wound, contact isolation, or urinary catheter. The baseline care plan did not include any goals or interventions. In an observation on 8/27/25 at 10:29 a.m., Resident #104 was sleeping in her bed, respirations were even and unlabored. There was a sign on the resident's door for contact isolation and to see the nurse for further instructions. A PPE cart was outside of the resident's room. In an observation on 8/28/25 at 10:00 a.m., wound care was completed as ordered for Resident #104 with no issues or concerns. The resident had a right AKA closed with staples that was free of redness, swelling, or drainage, and a urinary catheter with a privacy flap. In an observation and interviews on 8/27/25 at 4:45 p.m., LVN S stated she had made Resident #104's baseline care plan but was unable to locate it. LVN S logged in to their old computer program for medical records and the resident's information was not located. LVN S stated the MDS nurse had all other care plans on a jump drive and when she left for the day she left it with the nursing staff. LVN S escorted me to the MDS office and MDS T stated Resident #104 was a new admission so the resident's information would be with the ADON or DON. LVN S escorted me to that office and the ADON stated being the resident #104 was a new admission, medical records had the resident's information and care plan. The MR V was in her office and stated she had scanned over 128 resident medical records by resident but had not finished going through them all and renaming them for each resident as they were scanned in with generic file names and she would have to open each one to find it. MR V stated she was unable to supply the medical record papers that were scanned at this time. In an observation and interview on 8/28/25 at 10:30 a.m., Resident #104 was alert and oriented to person, and place initially but had some confusion. The resident stated she was doing okay and had pain but stated she was able to tolerate the wound care due to the staff pre-medicating her. The resident stated the staff at the facility provided wound and catheter care, pain management, and stated the staff fed her all her meals as she cannot do it for herself. The (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident stated her goal was to go home. In an interview on 8/30/25 at 1:07 p.m., the DON stated she was responsible for baseline care plans, but that Resident #104 had been admitted to the facility late on a Friday night, so the nurse had made the baseline care plan. The DON stated it was important for the baseline care plan to be completed so that nursing staff would know how to care for the resident. The DON stated the baseline care plan had been completed for Resident #104. In an interview on 8/30/25 at 4:45 p.m., with the DON and the ADON, they both stated the facility did not have a baseline care plan policy and they followed the RAI manual.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 2 of 6 Residents (Resident #76 and Resident #91) reviewed for care plans . The facility failed to include in Resident #76's comprehensive care plan that she had a self-performance deficit, and she was dependent on staff for all activities of daily living.The facility failed to include in Resident #91's comprehensive care plan that he had diabetes mellitus and received insulin on a regular basis. This deficient practice could place residents at risk of not receiving the care and services as needed. The findings were: 1. Record review of Resident #76's face sheet, dated 8/30/25, revealed she was admitted to the facility on [DATE] with diagnoses including muscle weakness (generalized), unsteadiness on feet and other lack of coordination. Record review of Resident #76's MDS, dated [DATE], revealed Resident #76's BIMS score was 12 of 15 reflective of moderate cognitive impairment and she was dependent on staff for all ADL's. Record review of Resident #76's Care Plan, dated 7/16/25, revealed it did not reflect that Resident #76 had a self-care performance deficit and was dependent on staff for all ADLs. Observation and interview on 08/26/25 at 12:34 PM revealed Resident #76 was sitting in a wheelchair eating her lunch meal. Resident #76 stated staff assisted her with ADLs. Interview on 08/30/2025 at 4:40 PM the MDS Coordinator/LVN T revealed Resident #76's Care Plan did not include Resident #76 was dependent on staff for all ADLs. She stated it was important that her ADL dependency was included so that all staff knew what they needed to do for the Resident and so everyone was on the same page in regard to the problem areas and approaches. LVN T stated the information was necessary so Resident #76 received the care and services as needed. 2. Review of Resident #91's face sheet, dated 8/28/25, revealed he was admitted to the facility on [DATE] with diagnoses including Type 2 diabetes mellitus (the body cannot use insulin correctly and sugar builds up in the blood) without complications and Major depressive disorder, recurrent, mild (pervasive low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities). Review of Resident #91's admission MDS assessment, dated 7/28/25, revealed his BIMS score was 13 of 15 reflective of minimal cognitive impairment, diagnosis of diabetes mellitus and it reflected he received insulin injections on a regular basis. Review of Resident #91's Diabetic flowsheet from 8/1/25 to 8/31/25 revealed an order for Humalog U-100 Insulin (insulin lispro) solution; 100 unit/mL;6 units, subcutaneous, Other Test: Before Meals administer 6 units before meals in addition to sliding scale for Type 2 diabetes mellitus without complications. Further review revealed a sliding scale order for insulin lispro, insulin pen; 100 unit/mL Review of Resident #91's Care Plan, dated 7/29/28, revealed it did not reflect that he had diabetes mellitus or that he was receiving insulin injections. Interview on 08/30/2025 at 4:40 PM with MDS Coordinator/LVN T revealed Resident #91's Care Plan did not include that Resident #91 had a diagnosis of diabetes mellitus and that he received insulin. She stated it was important that a resident's CP included all problem areas so all staff were on the same page and could identify the problem areas, goals and approaches when addressing the area of concern. LVN T stated the CP was a communication tool and the information was necessary so Resident #91 received the care and services as needed. Review of the facility's policy, titled, Care Plan - Resident, dated 12/2017, read in relevant part It is the policy of this home that staff must develop a comprehensive care plan to meet the needs of the resident. Procedure 1. Long-Term Goal a. Must be measurable and must related to the discharge objective (goal). Example: long-term goal - independent ambulation; discharge plan goal - return to home. b. Must be time limited. List a target date for the resident to achieve the long-term goal. [Review in ____ weeks/months] is not recommended since (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sometimes the date the goal was established is not clear. 4. Concerns and Problems a. Review CAA [Care Area Assessment] triggers on the MDS. If the interdisciplinary Team [IDCPT] decides to proceed with care planning, list the problem.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed ensure a resident with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for 1 of 6 Residents (Resident #54) whose records were reviewed. Nursing staff failed to apply a splint on Resident #54's right arm/wrist as tolerated for a right-hand contracture for 5 days, during the survey process. This deficient practice could affect residents with range of motion deficits and could contribute and result in a resident's decrease in their range of motion. The findings were: Review of Resident #54's face sheet, dated 8/30/25, revealed she was admitted to the facility on [DATE] with diagnoses including Vascular dementia (describing problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to your brain), moderate, withoutbehavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and Muscle wasting and atrophy (is the loss of muscle mass and strength; thinning or wasting of muscle tissue) not elsewhere classified, multiple sites. Review of Resident #54's quarterly MDS, dated [DATE], revealed her BIMS score was 4 of 15 reflective of severe cognitive impairment and she had a range of motion impairment on one side: upper and lower extremity. Upper extremity including (shoulder, elbow, wrist, hand). Review of Resident #54's Care Plan, dated 7/8/25, revealed Resident #54 had polyneuropathy and is at risk for increased pain, contractures, and skin breakdown. One of the approaches included RESIDENT MAY UTILIZE RIGHT HAND SPLINT AS TOLERATED TO ASSIST WITH DECREASING RISK OF PROGRESSION OF CONTRACTURE. Review of Resident #54's Occupational Therapy Plan of Care, dated 12/23/24, read Resident #54 was referred for therapy due to due to risk of decline without intermittent therapy. Without therapeutic intervention, patient is at risk for decline in range of motion. Underlying impairments. Range of motion RUE. Long term Goal(s) ROM The patient tolerates application of R RHS for 60 minutes in order to facilitate maximum ROM and joint alignment thus preventing deformity and pain. Goal 2/23/25. Review of Resident #54's progress notes for August 2025 did not reflect she had refused to have a splint applied to her right wrist/hand. Observation on 8/26/2025 at 12:27 PM revealed Resident #54 was sitting in a wheelchair in the dining room. She was being assisted with eating her lunch meal. Further observation revealed Resident #54 had a right-hand contracture and did not have hand rolls or a splint on. Observation and interview on 8/27/2025 at 11:17 AM revealed Resident #54 was sitting in a wheelchair by the dayroom. Attempted interview revealed Resident #54 did not engage in conversation. Further observation revealed Resident #54 had a right-hand contracture. Noted she did not have hand rolls or a splint on her arm/wrist. Observation and interview on 08/28/2025 at 5:32 PM revealed Resident #54 was sitting in a wheelchair by the dayroom. She did not have a hand roll or split applied on right arm/wrist. Observation and interview on 08/29/2025 at 5:05 PM CNA Y revealed she had worked at the NF for 2 years primarily from 6AM to 6PM. She stated she worked with Resident #54 on a regular basis, and she had never known Resident #54 to wear a splint on her right arm/wrist. She stated restorative CNA AA would help with splint application but again stated she had never seen Resident #54 wear a splint. Observation revealed CNA Y looking for a splint in Resident #54's closet and drawers. She stated she did not find one. Observation and interview on 08/29/2025 at 5:32 PM revealed Resident #54 was sitting in a wheelchair by the dayroom. She did not have a hand roll or splint applied on right arm/wrist. Resident #54 stated she was doing ok. Interview on 08/29/2025 at 5:40 PM with LVN Z revealed he had seen Resident #54 with a splint on her right hand/arm a couple of weeks ago. He stated she did not tolerate it for long. Interview on 08/30/2025 at 11:20 AM with the DON revealed Resident #54 refused to wear a splint since she started working at the facility about 2 months ago. She stated staff had tried to apply the splint and the Resident refused every time. The DON stated she had talked with Resident #54 who she (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated was able to answer simple questions. She stated Resident #54 told her she did not want to wear a splint. Observation and interview on 8/30/2025 at 11: 24 AM revealed Resident #54 was sitting in a wheelchair by the dayroom. She was drinking a milk shake. Resident #54 was not wearing a splint on her arm/wrist. Surveyor asked her if she was willing to wear a splint on her right hand/wrist to help straighten it? Resident #54 nodded her head, yes. Observation revealed the DON had joined Surveyor and Resident #54. Surveyor asked Resident #54 if anyone had tried to put one on and she shook her head, no. Further observation revealed the DON asked Resident if she wanted her to put the splint on? Resident #54 nodded her head, yes. The DON commented, you've said no before, but I will put it on if you want me to. Resident #54 again nodded her head, yes. The DON left and returned. She stated she was looking for the splint, but she could not find it.Interview on 8/30/2025 at 11:35 AM with the DON stated Resident #54 had never agreed to wear the splint. She stated the splint would help with her contracture/joint alignment. If she did not wear it her contracture would probably get worse. Review of facility policy titled, Activities of Daily Living, dated 12/2017, read in relevant part It is the policy of this home to assure residents have their activities of daily living needs met. Equipment1. Appropriate clothing.2. Appropriate footwear.3. Appropriate assistive devices.4. Grooming supplies. Surveyor did not obtain any other policy pertaining to this regulation.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews the facility failed to ensure food was stored, prepared, distributed and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for expired foods. The facility stored 13, 46 ounce, containers of thickened orange juice which were expired by 17 days. This deficient practice could place residents at risk for food borne illnesses. The findings included:During an observation on 8/26/2025 at 9:15 AM revealed the facility's kitchen pantry stored 13 46 oz. containers of thickened orange with manufactures labeling which included, best if used by [DATE]. During an interview on 8/26/2025 at 9:18 AM [NAME] G stated the thickened orange juice was stored in the pantry and was available for residents. The cook stated all staff were responsible for reviewing foods for expiration dates. The cook reviewed the thickened orange juice and stated the juice was expired and should not be stored and available for service. During an interview on 8/28/2025 9:33 AM the FSM stated the thickened orange juice was ordered before he began his tenure, and [NAME] G was responsible for ensuring foods in the pantry were within the expiration dates and failed to do so. The FSM stated the potential adverse reaction could be poor quality juice and or food borne illness. A dietary safe food policy was requested from the Administrator on 8/30/2025 at 7:52 PM to which the Administrator replied, the facility followed HHSC guidelines.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 4 residents (Resident #30), reviewed for infection control, in that: Resident #30 was provided high contact care and transferred from her bed to her wheelchair without the use of the appropriate EBP (Enhanced Barrier Precautions) on 8/27/25. This failure could place residents at risk of cross contamination. The findings were: Record review of Resident #30's face sheet dated 8/27/25 revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with readmission on [DATE]. Resident #30's diagnoses included Sacral spina bifida with hydrocephalus (a neural tube defect where the spinal column doesn't close completely, and buildup of excess cerebrospinal fluid in the brain), colostomy status (surgical opening (stoma) to divert stool outside the body), and pressure ulcer of sacral region, stage 4 (a localized injury to the skin or underlying tissue, usually over a bony prominence, as a result of unrelieved pressure-Stage 4 is full thickness tissue loss with possible exposed bone, tendon, or muscle). Record review of Resident #30's quarterly MDS assessment dated [DATE] revealed the resident had a BIMS score of 14 out of 15 indicating the resident was cognitively intact. The resident used a manual wheelchair, and was dependent on staff for lying to sitting, transferring, personal care, and bathing. The resident had an ostomy for bowel and an ostomy for urine, and a stage 4 pressure ulcer. Record review of Resident #30's care plan dated 7/17/25 revealed a problem with a start date of 5/13/25 for a stage 4 pressure ulcer to her sacrum with a goal it will show signs of healing and remain free of infection with multiple interventions. Problems with start dates of 4/30/25 for a colostomy and a urostomy (an opening (stoma) to divert urine outside the body) with a goal to remain free of infection with multiple interventions. A problem with a start date of 6/30/25 for EBP during contact care due to wounds and ostomies with a goal the resident will not have complications/interruption in daily routine related to the risk of MDRO (Multidrug-Resistant Organisms) by/through review date. Interventions included for staff to provide and utilize appropriate PPE along with standard precautions while providing resident care. (ie: ADL's (dressing, grooming, personal hygiene, transfers, linen changes, incontinent care/toileting, wound care, care to enteral tubes, IV sites, catheters, tracheostomy). In an observation and interview on 8/27/25 at 10:35 a.m. Resident #30 was in her room, in bed, OT U was standing at the resident's bedside wearing gloves and no gown and stated they were waiting for the CNA, and she was assisting with the resident's care. A sign on the door for EBP use that read providers and staff must wear gloves and a gown for high-contact resident care activities of dressing, bathing, transferring, changing linens, providing hygiene, or any skin opening requiring a dressing. Resident #30 stated she was waiting on the CNA who had just left the room to tell the nurse the urostomy bag is leaking. The resident stated she has a colostomy bag and a urostomy bag but the urostomy bag gives her more trouble than the colostomy bag and it leaks chronically and always has. CNA P entered Resident #30's room with a mechanical lift and stated she had informed the nurse and closed the door. In an observation and interview on 8/27/25 at 10:38 a.m. CNA P and OT U were standing on either side of Resident #30's bed wearing only gloves and no gowns. CNA P and OT U both stated they were providing care and transferring the resident to the chair. In an observation and interview on 8/27/25 at 10:47 a.m. CNA P opened Resident #30's door and the resident left in her wheelchair and stated she was headed to the dining room. CNA P and OT U did not have on gowns for EBP and were only wearing gloves. CNA P and OT U both stated they had provided high contact resident care and transferred Resident #30 without wearing a gown for EBP. In a telephone interview on 8/29/25 at 5:37 p.m. CNA P stated the surveyors made her very nervous and stated she was trained on EBP and knew that she should have been wearing a gown and gloves when caring for and transferring Resident #30 but surveyors in the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455713	A. Building B. Wing	08/30/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hallway made her nervous and she forgot. CNA P stated she always uses a gown and gloves per EBP protocol. In a telephone interview on 8/30/25 at 11:15 a.m. OT U stated she had been trained on EBP and knew she should have been wearing a gown and gloves for EBP but she was really nervous but normally always follows EBP by wearing a gown and gloves. In an interview on 8/30/25 at 1:07 p.m. the DON stated CNA P and OT U should have worn a gown and gloves for Resident #30's care and transfer and they had been trained previously and again recently. The DON stated it was important to wear the EBP PPE appropriately to prevent cross contamination. Review of in-service training report for EBP dated 8/27/25 was signed by 54 staff members including therapy and housekeeping and included CNA P and OT U. Review of staff training for OT U revealed she had been trained on EBP and PPE on 8/19/25. Review of staff training for CNA P revealed she had been trained on infection control to include PPE on 5/18/25 and confirmed through a skills checklist on this same date. Review of the facility policy on EBP revised 2/2025 indicated . 2. Employs targeted gown and glove use in addition to standard precautions during high contact resident care activities. 3. Examples of high contact resident care activities requiring the use of gown and gloves for EBP include a. dressing, c. transferring. h. wound care (any skin opening requiring a dressing).

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview and record review the facility failed to ensure they had reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request. The facility failed to ensure all survey results for the previous 3 years were available in the survey binder for residents and their family or legal representative or legal representative to examine. This deficient practice could place residents at risk of a violation of their rights. The findings were:Observation and interview on 8/29/25 at 10:07 AM revealed 7 unsampled residents attended the resident council meeting. Interview with the 7 unsampled residents revealed they did not know where to review the survey results. They did not know where they were located. Observation and record review on 8/29/25 at 12:09 PM in the facility lobby revealed a survey sign by the timeclock stating the survey binder with survey results was in the first drawer of the chest underneath the timeclock. Review of the survey binder revealed the survey results for 2023 were the only results filed in the binder. Further review revealed results of previous investigations or surveys were not in the binder. Interview on 8/29/25 at 12:20 PM with the ADM revealed she pulled the survey results for 2024 last week to review with the DON. She said she forgot to put them back. She stated the survey results should be readily accessible for the residents and visitors so they could be informed about the facilities compliance. She stated the residents, and the public had the right to know the facilities standing.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Many	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observations interviews and record reviews and in accordance with accepted professional standards and practices, the facility failed to ensure their medical records were maintained complete, accurate, readily accessible, and systematically organized for 92 of 92 residents reviewed for readily accessible and systematically organized medical records. On July 31st, 2025, the facility stopped using an electronic medical record database and began using paper charts to provide care for their residents and on 8/26/2025 the facility had a disorganized and decentralized medical records for their census of 92 residents. These failures could have potentially placed residents at risk for harm by disorganized and decentralized medical records. The findings included:The findings included: During an interview on 8/26/2025 at 10:00 the Administrator, the DON, and the ADON stated their census was 92 and currently the facility was using paper charts related to the facility's change over from the previous electronic medical record database platform to a new medical record database platform. The Administrator stated on 7/31/2025 the facility stopped adding data to the previous electronic medical record database platform and began using paper to document medical records. The Administrator and the DON stated they were expecting to have access to the new electronic medical record database platform by early August 2025; however, 26 days have elapsed without access to the new electronic medical record database platform. The DON and ADON stated they had developed and implemented a system of generating and storing medical records by having a system where the residents paper records were decentralized and diffuse throughout the facility to include each nurse generated medical records which were then turned into the various medical staff, for example, all consents were submitted to the ADON, the assessments were given to the MDS nurse for review, the orders and medication administration records were maintained at the 2 nurses stations and code status records were also kept in 2 separate binders which in turn were kept at two separate nurse stations. During intermittent observations at a minimum of 8 continuous hours a day from 8/26/2025 through 8/30/2025 revealed nurses, CNA's, therapy staff, and medical services providers generated medical records and maintained those records throughout the facility and with various locations without the use of centralized charts in a centralized location. During an interview on 8/27/2025 at 11:00 AM LVN A and LVN E stated they had not received formal training on developing centralized organized medical paper charts for each resident. LVN A stated the ADON had initiated a binder for each nurse hallway which included the residents for that hallway. The binder had orders, medication administration records, and progress notes, but did not have other record which could have included care plans, code status records, and or assessment records. During an interview on 8/30/2025 at 1:00 PM NP C stated the facility had not developed centralized paper charts and for the month of August 2025 and he has utilized the records available throughout the facility and had depended on the nursing staff for facilitation of the continuation of care and thus far has not had any negative outcomes. NP C stated a centralized paper chart would be the optimal situation until the electronic medical record could be achieved. A policy regarding the accurate, readily accessible, and systemically organized medical records was requested from the Administrator on 8/30/2025 at 7:52 PM to which the Administrator replied, the facility followed HHSC guidelines.

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review the facility failed to notify and send a copy of the residents' discharge notice to a representative of the Office of the State Long-Term Care Ombudsman when the facility transferred or discharged a resident under any circumstances for 1 of 6 months (July 2025) reviewed for discharge notices. The BOM failed to provide a copy of a list of residents who were discharged from the facility during July 2025 to the State Ombudsman. This deficient practice could place residents at risk of not being provided their right to discuss their options with the State Ombudsman. The findings were:Review of the facility transfer/discharge log from January 2025 through July 2025 revealed the list of residents transferred during July 2025 was not available as part of the notices that were sent to the State Ombudsman. Interview on 8/29/25 at 3:31 PM with the facility State Ombudsman stated she received discharges notice through June 2025 but had not received the discharge notices for July 2025. She also stated she had not received discharge notices for any facility-initiated discharge. Interview on 8/30/25 at 6:08 PM with the BOM stated she usually sent a list of residents from the facility by mid-month of the month after the residents had been discharged . She stated so typically she would have sent a notice of discharge notices by at least 8/15/25. However, because they were bought out by a different company she decided to wait until the end of August 2025 to ensure she had a complete and accurate list. The BOM stated she understood she should provide the State Ombudsman a notice prior to discharge when it was a facility-initiated discharge to ensure the resident had the opportunity to speak with the State Ombudsman if the resident wanted assistance to appeal from the State Ombudsman. The BOM stated she had not sent any notices to the State Ombudsman and stated this could result in a resident not having the opportunity to seek assistance as needed. Interview on 8/30/25 at 7:49 PM with the ADON stated the BOM manager was responsible for sending all discharge notices to the State Ombudsman. She stated she was not sure when the BOM sent them out, but the BOM would let administrative staff know when she did during morning meetings. The ADON stated for any facility-initiated discharges the BOM should send the notices to the State Ombudsman at the same time the resident was provided with a discharge notice. The ADON stated the resident had the right to seek assistance from the Ombudsman if the resident wanted to appeal the discharge. If not given this opportunity it would be a violation of the resident's rights to seek assistance. A request for a copy of the facility policy for Resident Rights was requested on 8/30/25 at 7:52 PM via email. The ADM responded she provided but did not provide a copy.